

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/23/2014	
NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaints IN00144648 and IN00146506 completed on April 2, 2014.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00147169, IN00147527, and IN00147856.</p> <p>Complaint IN00144648- Corrected.</p> <p>Complaint IN00146506- Corrected.</p> <p>Survey dates: April 21, 22, & 23, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF: 10 SNF/NF: 119 Total: 129</p> <p>Census payor type: Medicare: 12 Medicaid: 110 Other: 7 Total: 129</p> <p>Sample: 16</p> <p>Timberview Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 and 410 IAC 16.2 in regard to the PSR (Post Survey Revisit) to the Investigation of Complaints IN00144648 and IN00146506. Quality review completed on April 25, 2014, by Janelyn Kulik, RN.	{F 000}			